**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
Mark H Henry MD

**Respondent Name**
Travelers Indemnity Co

**MFDR Tracking Number**
M4-15-1540-01

**Carrier's Austin Representative**
Box Number 05

**MFDR Date Received**
January 26, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We find that none of the services billed on the claim were paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202."

**Amount in Dispute:** $2,122.64

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The medical records document that several days passed between the date of injury and the subsequent surgery. The Claimant saw several medical providers, none of whom documented and emergency nature of the Claimant's condition which would require immediate action. …Consequently, preauthorization was required for this surgical procedure under Rule 133.600 (p). Since preauthorization was not obtained, the Provider is not entitled to reimbursement."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 15, 2014 | 25609 | $2,122.64 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §133.10 defines emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - TR12 – Pre-auth not obtained prior to svc/proc being rendered

**Issues**

1. Is the Carrier liable for the services in dispute?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Labor Code §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;" Review of the submitted documentation finds;

    a. Clinical note dated 04/15/2014 – "Severity: Mild

    28 Texas Labor Code §133.2 (5) states, "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;" The definition of emergency not met.

    28 Texas Labor Code §134.600 (p) "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;" no prior authorization obtained, the Carrier is not liable for the services in dispute.
2. Requirements of Rule 134.600 not met. No additional payment can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | April , 2015 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.